STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005096	A. BUILDING: _____ B. WING _____	06/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCISCAN ST ELIZABETH HEALTH - LAFAYETTE I	1701 S CREASY LN LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for a State hospital complaint investigation. Date of Survey: 06/15/2016 Facility Number: 005096 Complaint # IN00189707 Substantiated, no state deficiencies related to the allegations are cited. QA: 7/26/16 jlh The Franciscan St. Elizabeth Health - Lafayette East is in complaince with 410 IAC 15-1.5-8 Physical Environment.	S 000		